Items 18&22aFilm 411 4-24-69 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02683 (02668)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First / Middle / Last	GEORGE BRUCE QUATTLEBAUM				2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month / Day / Year	2 - 8 1969
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN	2b. HOUR	1:45 PM
Male	White	4-25-25	43 YRS.		2c. DATE PRONOUNCED DEAD Month / Day / Year	2 / 8 / 1969
					2d. HOUR	1:45 PM
7a. BIRTHPLACE (State or foreign country)	Asheville, N.C.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH	Montgomery Md.
10. CITY OR TOWN OF DEATH	Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	20 Manchester Place #301	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Mont.	13c. CITY OR TOWN	S.S.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER	20 Manchester Place, #301					
14. FATHER'S NAME First / Middle / Last	Charles Quattlebaum			15. MOTHER'S MAIDEN NAME First / Middle / Last	Mary Addie Holstein	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	yes	(If so, give war or dates of service)	U.S. Army	16b. SOCIAL SECURITY NO.	579-22-1681-AA	
17. INFORMANT	Mrs. Mary A. Quattlebaum	ADDRESS	20 Manchester Pl. Silver Spring, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute bronchielitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
466X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) accompanied by acute ethylism
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.

EXAMINER'S NAME (Type) Belden R. Reap, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town or county) Suitland

22b. DATE SIGNED Feb. 8, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	February 11, 1969	Washington Nat'l. Cem.	Suitland, Maryland	
24. FUNERAL DIRECTOR	Paul J. Pumphrey	ADDRESS	8434 Georgia Avenue Silver Spring, Maryland	
Warner C. Pumphrey, Inc.				
25a. RECD BY REGISTRAR DATE	FEB 14 1969	25b. REGISTRAR'S SIGNATURE		

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02689 02684

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Elsa Middle: Z. Last: Quinn		2a. DATE OF DEATH Month: Feb. Day: 12 Year: 1969	2b. HOUR: 12:45 A.M.
3. SEX: Fem.	4. RACE: White	5. DATE OF BIRTH: Feb. 9 1895	6. AGE (In years last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Potomac Valley Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Medical Technologist	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Sumner	13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET AND NUMBER: 5001 Nahant Street
14. FATHER'S NAME First: Nicholas Middle: Zarth Last:		15. MOTHER'S MAIDEN NAME First: Anna Middle: Last: Freimulle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 077-32-8807-A	17. INFORMANT: Mr. Charles Quinn, Son, Address: 5001 Nahant St., Sumner, Maryland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonale — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Pulmonary Emphysema — 10 YRS.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492 X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Pyelonephritis & azotemia.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from 12/24/68, 19___, to 2/13/69, 19___, that (I) (we) last saw the deceased alive on 2/12/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry C. Scruggs MD — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 2/13/69

22d. PHYSICIAN'S NAME (Type): Henry C. Scruggs MD — 22e. ADDRESS: 5413 Cedar Lane Bethesda Md 20852

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 2-12-1969	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State): Suitland, Prince Georges Co. Md.
24. FUNERAL DIRECTOR — ADDRESS: Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016	25a. RECD BY REGISTRAR DATE: FEB 19 1969	25b. REGISTRAR'S SIGNATURE	

VR A15 (M) 45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02690

CERTIFICATE OF DEATH

02685

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
JENNIE		RATNER	2	15	69	6:15 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	May 25, 1896	72 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARITAL STATUS	9. COUNTY OF DEATH
Roumania	US A	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
TAKOMA PARK	WASH. SAN & HOSPITAL	Housewife	-0-

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	MONTGOMERY	TAKOMA PK.	YES ☒ NO ☐	7723 EASTERN AVENUE

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
unknown	unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No -----	579-03-6133A	Shirley Ratner, same as 13 above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		Approximate interval between onset and death
IMMEDIATE CAUSE (a)	Acute Coronary Insufficiency	4 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis.	2 years.
DUE TO, OR AS A CONSEQUENCE OF (c)	Hypertension	20 years.

4121

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Acute Myocardial Infarction 1967

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Jan., 1975, to 2/15, 1969, that (I) ~~(we)~~ last saw the deceased alive on 2/14 1969 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Samuel Dessoff M.D.		☑	☐	☐	2/15/69.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
SAMUEL DESSOFF	1302-18th St. N.W. Wash. D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-16-69	National Memorial Park	Falls Church, Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Goldberg Funeral Home	4217 9th Street NW	FEB 19 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

Items 18b&21c Film 410
B-18069 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02691 02686

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: ABRAHAM	Middle:	Last: RICHARDS	2a. DATE KNOWN OF DEATH ESTIMATED ☒: Month Feb. Day 22 Year 1969
2b. HOUR: P. M			
3. SEX: Male	4. RACE: Cauc.	5. DATE OF BIRTH: Aug. 15, 1909	6. AGE (In years last birthday): 59 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN
2c. DATE PRONOUNCED DEAD: Month Feb. Day 24. Year 19 69	2d. HOUR: 4:00 P. M		
7a. BIRTHPLACE (State or foreign country): England	7b. CITIZEN OF WHAT COUNTRY?: U. S.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Brookmont	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): rear of 6027 Broad St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Museum Specialist	12b. KIND OF BUSINESS OR INDUSTRY: Gov't
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Brookmont	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 6107 Broad Street			
14. FATHER'S NAME First: Abraham	Middle:	Last: Richards	15. MOTHER'S MAIDEN NAME First: Unknown	Middle:	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes. (If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 577-28-2341	17. INFORMANT: Wife	ADDRESS: Same as Item 13
Mildred L. Richards			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Drowning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 Minutes

9109

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ~~Due to acute alcoholism~~

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year: ~~XXXXX~~ P.M. 2-22- 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.): accidentally ~~XXXXXXXXXX~~ Fell in creek while intoxicated
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Creek	21f. LOCATION Street or R.F.D. No.: Rear of 6027 Broad St., City or Town: Brookmont, County: Montgomery, State: Md.

22a. **I certify** thot I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: John G. Ball M.D.

EXAMINER'S NAME (Type): JOHN G. BALL

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: 2-24-69

ADDRESS(Street, city, town, or county): Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-27-69	23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State): Rockville, Maryland	
24. FUNERAL DIRECTOR ADDRESS: ROBERT A. PUMPHREY, Bethesda, Maryland	25a. REC'D BY REGISTRAR DATE: FEB 26 1969	25b. REGISTRAR'S SIGNATURE: [signature]		

VR A15ME (5) 10M REV. 1/68

FOR STATE HEALTH DEPT.

02692

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02687

1. DECEASED-NAME (Type or Print)	First — Laurette	Middle — Martin	Last — Richter					2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☒	Month Feb	Day 18	Year 1969	2b. HOUR ? M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.	2c. DATE PRONOUNCED DEAD	Month Feb	Day 20	Year 1969	2d. HOUR 11 35 M
F.e	W.	July 4 1906	62 YRS.									

7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Chevy Chase Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4001 Underwood Street	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER 4001 Underwood St.

14. FATHER'S NAME First GEORGE	Middle V.	Last MARTIN	15. MOTHER'S MAIDEN NAME First MAYME	Middle Last LANDRY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Dr. Geo. V. Martin	ADDRESS Brother

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Gastric Hemorrhage Massive	2 hr. Pt.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3032	DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Alcoholism.	
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John S. Ball M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county)
22b. DATE SIGNED Feb 21 1969.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-25-69	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem	23d. LOCATION (City or Town) Arlington	(County) (State) Va
24. FUNERAL DIRECTOR Robert A. DeSoe	ADDRESS DeSoe Funeral Home Wash D.C.	25a. REC'D BY REGISTRAR DATE MAR 3 1969	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

02693

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02688

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JAMES	FORREST	RISSLER	FEB. 21 1969	10 20 AM

3. SEX	4. RACE	5 DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
MALE	WHITE	FEB. 17, 1969			3	1D	53

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
MARYLAND	U. S. A.		MONTGOMERY, Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	HOLY CROSS HOSP.	NONE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	PRINCE GEORGES	GREENBELT	YES ☒ NO ☐	8407 GLENN DALE ROAD

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
ROBERT	F	RISSLER	KATHRYN		HANEY

16a. WAS DECEASED EVER IN U S ARMED FORCES? Yes, no, or unknown)	If yes give war or dates of service,	16b. SOCIAL SECURITY NO	17 INFORMANT	Address
NO		NONE	ROBERT F. RISSLER	8407 GLENN DALE RD. GREENBELT MD. 20770

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory failure
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
No

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No	No	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that (I) (this hospital) attended the deceased from 2/17, 19 69, to 2/21, 19 69, that (I) (we) last saw the deceased alive on 2/21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
Marvin Monies	MD				2/21/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MARVIN MONIES	9801 Georgia Ave Silver Spring

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	FEB 22, 1969	WASHINGTON NATIONAL CEM.	SUITLAND, PRINCE GEORGES, MARYLAND

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS CO.	RIVERDALE, MD.	FEB 26 1969	Charles Judge

VR A15.1
30M REV 1-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

02694

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Item5 Film6409 2/17/69 kk

02689

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First / Middle / Last	Brian Keith Roberts	2a. DATE OF DEATH Month Day Year	February 8, 1969
2b HOUR	1:20 P.M.		
3 SEX	Male	4. RACE	White
5. DATE OF BIRTH	November 24, 1954	6 AGE (In years last birthday)	14 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b CITIZEN OF WHAT COUNTRY?	America
8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐		9 COUNTY OF DEATH	Montgomery Md.
10 CITY OR TOWN OF DEATH	Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Washington Sanitarium
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	none	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	Maryland	13b COUNTY	Montgomery
13c CITY OR TOWN	Silver Spring	13d INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET AND NUMBER	716 Dennis Avenue		
14 FATHER'S NAME First / Middle / Last	William Roberts	15 MOTHER'S MAIDEN NAME First / Middle / Last	Juanita Byrd
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	no	16b SOCIAL SECURITY NO	none
17 INFORMANT Address	Patient's chart		

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(a) IMMEDIATE CAUSE: URI + possible GI bleeding

(b) DUE TO, OR AS A CONSEQUENCE OF: metachromatic leukodystrophy of CNS

(c) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	—	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES ☒ NO ☐		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While at work ☐ Not while at work ☐		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	—
21f LOCATION Street or R.F.D. No. / City or Town / County / State			

22a I **certify** that (I) (~~this hospital~~) attended the deceased from Jan 1, 1961, to Feb 8, 1969, that (I) (we) last saw the deceased alive on 2/7/1969, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b SIGNATURE	R H Sandstrom MD	DEGREE: ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐	22c DATE SIGNED 2/8/69
22d. PHYSICIAN'S NAME (Type)	R. H. Sandstrom MD	22e ADDRESS	7701 Carroll Ave TP MD

23a BURIAL CREMATION, REMOVAL (Spec'fy)	Burial	23b DATE	2-13-69	23c NAME OF CEMETERY OR CREMATORY: Ft Lincoln
23d LOCATION (City or Town) (County) (State)	Bladensburg, Maryland			
24 FUNERAL DIRECTOR	Collins Funeral Home	ADDRESS	7701 University Blvd Silver Spring Md	25a RECD BY REGISTRAR DATE: FEB 11 1969
25b REGISTRAR'S SIGNATURE				

VR A15 (Rev.) 45M - 1-68

Items 18&22a Film 410 MARYLAND STATE DEPARTMENT OF HEALTH
3-24-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02696 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02690

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) First: RAY	Middle: N.	Last: RUBIN	2a DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month: 2 Day: 20 Year: 1969	2b HOUR: 445 M		
3 SEX: Fe	4 RACE: CAUC	5 DATE OF BIRTH	6 AGE (In years last birthday): 70 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month: 2 Day: 20 Year: 1969	2d HOUR: 445 M
7a BIRTHPLACE (State or foreign country): Russia	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery				Md
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b. COUNTY: Montgom	13c CITY OR TOWN: Sil. Sp.	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 1001 Spring Street			
14. FATHER'S NAME First: Philip	Middle	Last: Heilig	15 MOTHER'S MAIDEN NAME First: unknown	Middle	Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Bernard G. Rubin,	ADDRESS: 3901 Sunlaw Rd.N.W. Wash., D.C.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Leaking abdominal aortic aneurysm with exsanguination — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4 h, 1 d

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☒ NO ☐	
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm street factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Beloen R. Reap M.D.
EXAMINER'S NAME (Type): BELOEN R. REAP M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, City or Town, County): Bethesda
22b. DATE SIGNED: Feb. 20, 1969

23a BURIAL CREMATION REMOVAL (Specify): Burial	23b DATE: 2/21/69	23c NAME OF CEMETERY OR CREMATORY: Ohev Sholom Talmud Torah Cong.	23d LOCATION (City or Town) (County) (State): Wash., D.C.	
24 FUNERAL DIRECTOR: BERNARD DANZANSKY & SONS	ADDRESS: 3501-14th St. N.W. Wash, D.C. 20010	25a RECD BY REGISTRAR DATE: FEB 24 1969	25b REGISTRAR'S SIGNATURE: Charles Yingst	

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02697

CERTIFICATE OF DEATH

02691

1. DECEASED-NAME (Type or print): First Elizabeth Middle Lee Last Russell
2a. DATE OF DEATH: Month Feb Day 25 Year 69
2b. HOUR: 9:35 PM
3. SEX: F
4. RACE: White
5. DATE OF BIRTH: April 1 1888
6. AGE (In years last birthday) If under 1 year: Months / Days; If under 24 hrs: Hours / Min: 80 YRS.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address): Suburban
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Clerk U.S. Govt.
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Maryland.
13b. COUNTY: BALTO.
13c. CITY OR TOWN: Colesville
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 7101 Kalmia Road
14. FATHER'S NAME First John Middle Coleman Last Russell
15. MOTHER'S MAIDEN NAME First Sara Middle Elizabeth Last Baker
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No. (If yes give war or dates of service)
16b. SOCIAL SECURITY NO. 220-44-0677
17. INFORMANT: Agnes K. Stedman Address 4602 Bonn Bridge Rd Bethesda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7a Min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Arterio-sclerotic cardiovescular disease Yrs.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Electrolyte imbalance

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)
21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from 2-22, 1969, to 2-25, 1969, that (I) (we) last saw the deceased alive on 2-25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alfred S. Norton M.D. DEGREE — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 2/25/69
22d. PHYSICIAN'S NAME (Type): Alfred S. Norton
22e. ADDRESS: Bethesda Suburban Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-1-69
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City or Town) (County) (State): Balto. City, Baltimore, Md.
24. FUNERAL DIRECTOR: Howard H. Hubbard
ADDRESS: 4107 Wilkens Ave. 21229
25a. RECD BY REGISTRAR DATE: MAR 3 1969
25b. REGISTRAR'S SIGNATURE: Elsworth Dodge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S 03
45M - 1-68

02693

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: PAULINE	Middle: M	Last: RUSSELL	2a. DATE OF DEATH: 2 Month 27 Day 69 Year	2b. HOUR: 8 AM M
3. SEX: FEMALE	4. RACE: White	5. DATE OF BIRTH: 3/11/11	6. AGE (In years last birthday): 57 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): N. J.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: MONTGOMERY Md		
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b. COUNTY: A. A.	13c. CITY OR TOWN: ANNAPOLIS	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: Greenbriar Lane	
14. FATHER'S NAME First: Robert	Middle:	Last: Morrow	15. MOTHER'S MAIDEN NAME First: Pauline	Middle:	Last: Brown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: Charles Russell	Address: # 13	

MED CAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Uraemia due to Ureteral

1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Ca from Colon

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Jan, 1969, to 2-27, 1969, that (I) (we) last saw the deceased alive on 2-26 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death

22b. SIGNATURE: Bernard H. Ostrow	DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED: 2-27-69	
22d. PHYSICIAN'S NAME (Type): BERNARD H. OSTROW	22e. ADDRESS: 8107 Eastern Ave. S.S., Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-28-69	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest	23d. LOCATION (City or Town): Annapolis	(County): A.A. (State): Md.
24. FUNERAL DIRECTOR: John M. Taylor Sons	ADDRESS: Annapolis Md.	25a. REC'D BY REGISTRAR DATE: MAR 3 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 30M REV 68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02659 02693

1 DECEASED-NAME (Type or print): First Robert; Middle NMN; Last Rynich

2a. DATE OF DEATH: Month February Day 13 Year 1969

2b. HOUR: 9:00 P.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: 17 September 1939

6. AGE (In years last birthday): 29 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (State or foreign country): Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): The Clinical Center

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer

12b. KIND OF BUSINESS OR INDUSTRY: Packing Co.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Pennsylvania

13b. COUNTY

13c. CITY OR TOWN: Swoyersville

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 419 Owen Street

14. FATHER'S NAME: First (Unknown) Middle Last

15. MOTHER'S MAIDEN NAME: First Mary Middle Last Rynich

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO. 202-30-5492

17. INFORMANT: The Medical Record Address: The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hepatic Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 days

1729

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Metastatic Malignant Melanoma — Years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that ☒ (this hospital) attended the deceased from 29 Jan., 1969, to 13 Feb., 1969, that ☒ (we) last saw the deceased alive on 13 February 1969, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE: Sherrard L. Hayes MD DEGREE — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22c. DATE SIGNED: 14 February 1969

22d. PHYSICIAN'S NAME (Type): Sherrard L. Hayes, M.D.

22e. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried

23b. DATE: 2-18-69

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City or Town) (County) (State): Wilkes-Barre Penna.

24. FUNERAL DIRECTOR: W. W. Chambers Co ADDRESS: 1400 Clifton St. N.W. Wash D.C.

25a. REC'D BY REGISTRAR DATE: FEB 20 1969

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
30M REV. 1-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02700 .2694

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print): First Anna Middle C. Last Saffell

2a. DATE OF DEATH: Month 2 Day 25 Year 69

2b. HOUR: 11:[illegible] M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: 1-11-95

6. AGE (In years last birthday): 74 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN

7a. BIRTHPLACE (State or foreign country): Rhode Island

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md

10. CITY OR TOWN OF DEATH: Bethesda

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: own home

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.

13b. COUNTY: Mont.

13c. CITY OR TOWN: Bethesda

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: East West Highway Apt. 704 - Topaz House

14. FATHER'S NAME: First (Unknown) Middle Last

15. MOTHER'S MAIDEN NAME: First (Unknown) Middle Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16b. (If yes give war or dates of service) --

16b. SOCIAL SECURITY NO: 577-03-5428 yes

17. INFORMANT: Mrs. John Panagos Address: Bells Mill Rd. Potomac, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS WITH HEMIPLEGIA, LEFT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

4337

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS, GEN. — 5 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ARTERIOSCLEROTIC HEART DISEASE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)

21f. LOCATION Street or R.F.D. No City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from JAN, 19 6X, to FEB. 25, 19 69, that (I) (~~we~~) last saw the deceased alive on FEB. 25 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Leo M. Curtis M.D. DEGREE — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22c. DATE SIGNED: 2-25-69

22d. PHYSICIAN'S NAME (Type): Leo M. Curtis, M.D.

22e. ADDRESS: 8718 Wisconsin Avenue, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 2-28-1969

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: C. Glen Carter ADDRESS: Sil. Spr., Md.

Warren E. Murphrey, Inc. 8434 Georgia Avenue

25a. RECD BY REGISTRAR DATE: FEB 28 1969

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

0270 — 02695

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Roberto		SALKELD	FEB	2	69	3:30 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	CAUCASION	14 NOV 39	29 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PERU	PERU	MARRIED X	MONTGOMERY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL	NAVAL OFFICER	

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
D.C.		WASHINGTON	YES X NO	5480 WISCONSIN AVE.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
HORACIO		SALKELD	ELVIRA		ANGULO

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes, give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
NA		NA	MARIA LUISA DE SALKELD, 5480 WISCONSIN AVE.	WASHINGTON, D.C.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1741

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO X	

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I (this hospital) attended the deceased from 6 DEC, 19 68, to 2 FEB, 19 69, that I (we) last saw the deceased alive on 2 FEB 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
T. M. Schenk			X		2 FEB 69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
T. M. SCHENK, M. D.	NAVAL HOSPITAL, BETHESDA, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	2-5-1969	STANGEL CEMETERY	LIMA PERU

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W W Chambers	1400 Chapman St NW	FEB 6 1969	

Items10&11 Fil...09 MARYLAND STATE DEPARTMENT OF HEALTH ...22aFilm 109 2-20-69ams

2/20/69 0270D DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02696

FOR STATE HEALTH DEPT.

1 DECEASED NAME (Type or Print)	First: Joseph	Middle: F.	Last: Sambuco	2a DATE KNOWN OF DEATH / ESTIMATED	Month: X	Day: 2/6	Year: 1969	2b HOUR: 10:00 AM
3. SEX: male	4. RACE: white	5 DATE OF BIRTH: 3/9/62	6 AGE (In years if 1 day old) YRS: 6	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c DATE PRONOUNCED DEAD: Month	Day: 2/6	Year: 1969	2d HOUR: 10:30 AM

7a BIRTHPLACE (State or foreign country): California	7b CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery	Md
10. CITY OR TOWN OF DEATH: Kensington Md. Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Holy Cross Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Montg.	13c CITY OR TOWN: Kensington	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 3402 Oberon Street

14. FATHER'S NAME First: Albert	Middle: J.	Last: Sambuco	15. MOTHER'S MAIDEN NAME First: Antonina / Middle / Last: Rizzo
16a. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT: father ADDRESS: same

MEDICAL CERTIFICATION

B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute, purulent meningitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3200

Conditions, if any which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Hemophilus influenzae, type B, by

DUE TO, OR AS A CONSEQUENCE OF (c): anti-sera typing.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D No	City or Town	County / State

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): BELDEN R. REAP M.D. Bethesda

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MED CAL EXAMINER ☒

22b. DATE SIGNED: Feb. 6, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
BURIAL	2-10-69	Gate of Heaven	Silver Spring,		Maryland.

24. FUNERAL DIRECTOR: Francis Keefer ADDRESS: 500 Univ. Blvd. W. Silver Spring, Md.

25a REC'D BY REGISTRAR DATE: FEB 11 1969

25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's office along with form MMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02709 02697

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First Walter Middle R Last Schrader
2a. DATE OF DEATH: Month 2 Day 22 Year 69
2b. HOUR: 4:14 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Sept 19, 1923
6. AGE (In years last birthday): 45 YRS. IF UNDER 1 YEAR: MONTHS 5 DAYS 3 IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Montgomery Md
10. CITY OR TOWN OF DEATH: Rockville Md.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Potomac Valley N. Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Meatcutter
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Rockville
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 1615 Lewis Ave.
14. FATHER'S NAME First Middle Last: Unknown
15. MOTHER'S MAIDEN NAME First Middle Last: Eulia ---
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII
16b. SOCIAL SECURITY NO: 092-12-3395
17. INFORMANT Address: Lucille Schrader- wife-same item # k3A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b): Asteriosclerosis — 3 Mos.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 1929

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 11/31/68, 19__, to 2/22/69, 19__, that (I) (we) last saw the deceased alive on 2/21/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry C. Scruggs DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22c. DATE SIGNED: 2/22/69
22d. PHYSICIAN'S NAME (Type): Henry C. Scruggs
22e. ADDRESS: 7720 Wisconsin Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/25/69
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City or Town) (County) (State): Rockville, Montg. Maryland

24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home
ADDRESS: 1331 Rock. Pike Rockville, Maryland
25a. REC'D BY REGISTRAR DATE: FEB 26 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 Rev 45M 1-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 45M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02704 02698

1. DECEASED-NAME (Type or print) First: Douglas	Middle: W	Last: Seitzinger	2a. DATE OF DEATH Month: Feb	Day: 7	Year: 1969	2b. HOUR: 9:50 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 2/1/04	6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.			
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired	12b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md	13b. COUNTY: Mont	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 263 Congressional Lane		
14. FATHER'S NAME First: ?	Middle:	Last: Seitzinger	15. MOTHER'S MAIDEN NAME First: Esther	Middle:	Last: Keihn	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address: Marian F. Seitzinger-Item # 13				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Hepato-renal syndrome and liver failure
DUE TO, OR AS A CONSEQUENCE OF (b): Cirrhosis of liver
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 5719
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Twelve months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Bleeding esophageal varices

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Dec 27, 1968 to Feb 7, 1969, that (I) (we) last saw the deceased alive on Feb 6 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert N. Coale		☒	☐	☐	Feb 7, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
ROBERT N. COALE	5411 Cedar Lane Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/10/69	Rockville	Rockville, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home-1331 Rockville Pike	Rockville, Md.	FEB 13 1969	J. Chandler Young

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02705 — 02699

1 DECEASED NAME (Type or print): First CARMELA; Middle; Last SERIO

2a DATE OF DEATH: Month Feb; Day 8; Year 1969

2b HOUR: 2 45 P.M.

3 SEX: FEMALE

4 RACE: WHITE

5. DATE OF BIRTH: OCT. 16, 1885

6 AGE (In years last birthday): 83 YRS.

If UNDER 1 YEAR: MONTHS; DAYS. If UNDER 24 HRS.: HOURS; MIN.

7a BIRTHPLACE (State or foreign country): ITALY

7b CITIZEN OF WHAT COUNTRY? ITALY

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

9 COUNTY OF DEATH: MONTGOMERY — Md

10 CITY OR TOWN OF DEATH: SILVER SPRING MD

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): FAIR LAND

12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSE WIFE-MOTHER

12b KIND OF BUSINESS OR INDUSTRY:

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md

13b COUNTY: MONT. SILVER SPRING Md.

13c CITY OR TOWN:

13d INSIDE CITY LIMITS? YES ☑ NO ☐

13e STREET AND NUMBER: 1001 Univ. Blvd. East

14 FATHER'S NAME: First EMMANUELE; Middle RAPISARDI; Last

15 MOTHER'S MAIDEN NAME: First FILIPPA; Middle; Last DI MATTEA

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16b SOCIAL SECURITY NO. 220-54-0239-S

17 INFORMANT: MANUEL SERIO (SON) Address 1001 Univ. Blvd. East

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiac Insufficiency + Circulatory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO, OR AS A CONSEQUENCE OF

(b) General arteriosclerosis (Cerebral) — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c) Central Hypertension — 20 years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Old age —

19a DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a AUTOPSY? YES ☐ NO ☑

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐

21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from Jan, 1930, to 2/5/, 1967, that (I) (~~we~~) last saw the deceased alive on 2/5/ 1967, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (~~did not~~) view the body after death.

22b SIGNATURE: R.N. Manganaro M.D. — DEGREE: ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22c. DATE SIGNED: 2/8/69

22d PHYSICIAN'S NAME (Type): R.N. MANGANARO M.D.

22e ADDRESS: 1410 MASS. AVE. N.W. WASHINGTON D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE: 11 FEB 1968

23c NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY

23d LOCATION (City or Town) (County) (State): WASHINGTON DC.

24 FUNERAL DIRECTOR: GINNI FUNERAL HOME INC. ADDRESS: 7400 GEORGIA AVE., WASHINGTON D.C. 20012

25a RECD BY REGISTRAR DATE: FEB 13 1969

25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02706

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02706

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
Evelyn	?	Sharfman	☒	2	17	1968	12 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN	2c. DATE PRONOUNCED DEAD: Month	Day	Year	2d. HOUR
Female	White	11/30/68	3mos					2	17	1969	12 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Montgomery Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret red.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	minor	minor

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Sil. Spg.	YES ☒ NO ☐	1124 Caddington Ave. SSMd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jerome	E	Sharfman	Valerie	B.	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
none			parents	1124 Caddington Ave. SSMd.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Meningitis, Etiology Unknown

DUE TO, OR AS A CONSEQUENCE OF (c) SDI.I

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Keep M.D.

EXAMINER'S NAME (Type) BELDEN R. KEEP, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) [illegible]

22b. DATE SIGNED Feb. 17, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	2-18-69	Beth David Cem	Belmont, L.D. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD. BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
B. Danganstein & Sons	3501-14th St. N.W.	FEB 20 1969	[signature]

VR A15ME (5) 10M REV 1/68

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02707

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Elaine	Middle: Ellen	Last: Shaw
2a. DATE OF DEATH Month Day Year	February 16 1969	2b. HOUR	7:20 A M
3. SEX	Female	4. RACE: White	5. DATE OF BIRTH: 5 July 1916
6. AGE (In years last birthday)	52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH	Montgomery Md.		
10. CITY OR TOWN OF DEATH	Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	The Clinical Center
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	West Virginia	13b. COUNTY	
13c. CITY OR TOWN	Charleston	13d. INS DE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: Route #5, Box 571
14. FATHER'S NAME First	Dow	Middle	Kelley
15. MOTHER'S MAIDEN NAME First	Elizabeth	Middle	Martin
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	NO	16b. SOCIAL SECURITY NO	UNKNOWN
17. INFORMANT	The Medical Record	Address	The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Klebsiella Pneumonia; probable pseudomonas; septicemia; — Approximate interval between onset and death: 14 days

2050

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Pyelonephritis; probable pseudomonas — 14 days

DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myelocytic Leukemia — 10 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (X) (this hospital) attended the deceased from 30 Jan, 19 69, to 16 Feb., 19 69, that (X) (we) last saw the deceased alive on 16 February 19 69, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Harmon J. Eyre M.D. DEGREE — ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [X] — 22c. DATE SIGNED: 16 February 1969

22d. PHYSICIAN'S NAME (Type): Harmon J. Eyre, M.D. — 22e. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 2-19-69	23c. NAME OF CEMETERY OR CREMATORY: John Beane Co.	23d. LOCATION (City or Town) (County) (State): Charleston, W. Va.	
24. FUNERAL DIRECTOR: W. W. Chambers Co. Wash. D. C.	ADDRESS: 1400 Chapin St. NW	25a. RECD BY REGISTRAR DATE: FEB 19 1969	25b. REGISTRAR'S SIGNATURE	

VR A15 (4) 30M REV. 1/68

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02708

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then release remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
Sallie	Nutwell	Shepherd	February 20 1969	5:55 P.M.

3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
F	W	April 26, 1878	90 YRS.	10			

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Gaithersburg	Asbury Methodist Home	Housewife	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland		Harwood		-----

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Isaac	S.	Nutwell	Roberta		Winterson

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give [redacted] of service)	16b. SOCIAL SECURITY NO	17 INFORMANT Address
NO	215-54-8222-J1	Asbury Methodist Home, Gaithersburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(b) a severe congestive failure. — 3 mos

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Bronchopneumonia

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 7/1/68, 19___, to 2/20/69, 19___, that (I) (we) last saw the deceased alive on 2/19/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Henry C. Scruggs	MD				2/20/69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
Henry C. Scruggs MD	54-13 Cedar Lane Bethesda

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	Feb 22-69	Mt. Zion	(Near) Lothian		Md

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ernest C. Gaither. Gaithersburg.	FEB 24 1969	Clerk or Judge

VR A15 30M REV 1-68

1

FOR STATE HEALTH DEPT.

Items 13&22a Film 410
3-14-69 am

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02703

1 DECEASED NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ☒ / ESTIMATED ☐ Month Day Year	2b HOUR
May	J.	Slawson	Feb. 25 1969	12:45 AM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	April 29, 1882 (May)	86 YRS			February 25 1969	12:45 AM

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Wisconsin	America		Montgomery Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington San & Hospital	none	Housewife

13a USUAL RESIDENCE (Where deceased lived if institution: Res dence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Pr. Geo.	Mt. Rainier	YES ☒ NO ☐	4609- 27th St.

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
August		Jacobson	Elizabeth		Pollack

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	none	Unknown	Patient's Chart	

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute coronary insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4123
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R F D No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Reap M.D.

EXAMINER'S NAME (Type) Belden R. Reap M.D. Silver Spring Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED Feb. 25, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Cremation	3-4-1969	Foet Lincoln Cemetery	Colmar Manor Md

24 FUNERAL DIRECTOR ADDRESS	25a REG. NO.	REG. FUNERAL DIRECTOR'S SIGNATURE
Valley Funeral Home Mt Rainier Md	DATE MAR 6 1969	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1.6

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02710

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Valeria	M	Sledge	2 14 69	1:30 P.M.

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Female	White	Dec. 25, 1897	71 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Md.	U.S.A.		Montgomery Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Takoma Park	Wash. San. & Hospital	Ret.-DC Chamber of Commerce	

13a. USUAL RESIDENCE (Where deceased admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Md.	Montg.	Silver Spring		12303 Judson Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Arthur	C.	Mullican	Nettie	--	Kisner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
No		Margaret L. Duncan, Same as # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Insuffy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Chronic

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 1945, 19__, to 2/14/69, 19__, that (I) ~~(we)~~ last saw the deceased alive on 2/14/69 19__, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22c DATE SIGNED
A.C. Leonardo M.D.			2/14/69

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
A.C. LEONARDO	5801-13th St. N.W. Washington D.C.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	2/17/69	Cedar Hill Cemetery	Suitland, Maryland

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Jos. Gawler's Sons, 5130 Wis. Ave, Wash., D.C.	FEB 19 1969	

VR A15 45M 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02711 02705

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. DECEASED-NAME (Type or print): First: Dorothy; Middle: Mae; Last: Smith
2a. DATE OF DEATH: Month: February; Day: 10; Year: 69
2b. HOUR: 8:46 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: March 6, 1896
6. AGE (If years last birthday): 72 YRS
If UNDER 1 YEAR: MONTHS / DAYS
If UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Michigan
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Montgomery Md
10. CITY OR TOWN OF DEATH: Wheaton
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wheaton Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired): N.G.A.
12b. KIND OF BUSINESS OR INDUSTRY: Govt.
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 5708 Lonoak Drive
14. FATHER'S NAME: First / Middle / Last: (Unknown)
15. MOTHER'S MAIDEN NAME: First / Middle / Last: (Unknown)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --
16b. SOCIAL SECURITY NO.: 220-54-1666
17. INFORMANT: William F. Smith Address: 5708 Loneoak Drive, Bethesda Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pulmonary embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1/2 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): Bronchopneumonia and atherosclerosis — 2 days
DUE TO, OR AS A CONSEQUENCE OF (c): heart disease — years
485 X
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis; Diverticulosis coli; osteoporosis
19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from May 19 65, to 2-10 19 69, that (I) ~~(we)~~ last saw the deceased alive on 2-9 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ ~~(did not)~~ view the body after death.

22b. SIGNATURE: John Geiger M.D. DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 2-10-69
22d. PHYSICIAN'S NAME (Type): JASON GEIGER, M.D.
22e. ADDRESS: 810 PERSHING DRIVE SILVER SPRING, MD. 20910

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-17-1969
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City or Town) (County) (State): Arlington, Virginia
24. FUNERAL DIRECTOR: C. Glen Carter — Warner E. Pumphrey, Inc. ADDRESS: Sil. Spr., Md. 8434 Georgia Avenue
25a. REC'D BY REGISTRAR: DATE FEB 19 1969
25b. REGISTRAR'S SIGNATURE:

VR A1S (4) 45M 1/69

1

Item 18-22a Film 410 MARYLAND STATE DEPARTMENT OF HEALTH
5-10-69 am DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
02712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02706

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: EVA	Middle: JEAN	Last: SMITH	2a. DATE OF DEATH KNOWN [X] EST. [ ] Month Day Year: 2-17-69	2b. HOUR: M
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: June 5, 1925	6. AGE (In years last birthday): 43 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month 2 Day 17-69 Year 19	2d. HOUR: 11:20 PM
7a. BIRTHPLACE (State or foreign country): Wash., D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md
10. CITY OR TOWN OF DEATH: Kensington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 10404 Meredith Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret red.): Nurse	12b. KIND OF BUSINESS OR INDUSTRY: R.N.
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE: Md.	13b. COUNTY: Mont.	13c. CITY OR TOWN: Kensington	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 10404 Meredith Ave.
14. FATHER'S NAME First: John	Middle: W.	Last: Harpine	15. MOTHER'S MAIDEN NAME First: Irene	Middle: --	Last: Shenk
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No (If yes give war or dates of service):	16b. SOCIAL SECURITY NO.: Yes	17. INFORMANT: William J. Smith	ADDRESS: Kensington, Md. 10404 Meredith Avenue

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorespiratory failure	
DUE TO, OR AS A CONSEQUENCE OF (b)	due to barbiturate intoxication	
DUE TO, OR AS A CONSEQUENCE OF (c)		

9500

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year: HOUR 2:00 P.M. 2-17 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Deceased, depressed, took overdose of barbiturate
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Kensington Montgomery Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Belden R. Reap M.D

EXAMINER'S NAME (Type): Belden R. Reap, MD

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS (Street, City, Town or County): Rockville

22b. DATE SIGNED: Feb. 18, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-20-1969	23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park	23d. LOCATION (City or Town) (County) (State): Falls Church, Virginia
24. FUNERAL DIRECTOR: C. Glen Carter Warner E. Pumphrey, Inc.	ADDRESS: Sil. Spr., Md. 8434 Georgia Avenue	25a. RECD BY REGISTRAR DATE: FEB 21 1969	25b. REGISTRAR'S SIGNATURE

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

02713

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02707

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b HOUR
John	Mitchell	Smoot	2	16	1969	3:05 P.M.

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR
Male	Cau.	Dec 22, 1908	60 YRS					2	16	1969	3:05 P.M.

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Va.	U.S.A.		Montgomery Md.

10. CITY OR TOWN OF DEATH	NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	95 East Wayne Ave.	Retired	Dept Store Executive

3a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Mont.	Silver Sp.	YES ☒ NO ☐	95 East wayne Ave.

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John M.		Mitchell	Emma		Chapman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	WW 2	416-03-8569	Olga Smoot	95 E. Wayne Ave.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute Coronary Insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

41

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒; and in my opinion death resulted from, Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden K. Reap M.D.

EXAMINER'S NAME (Type) BELDEN K. REAP, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town or county) Silver Spring

22b. DATE SIGNED Feb. 16, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Cremation	2/19/69	Ft. Lincoln	Bladensburg Md.

24 FUNERAL DIRECTOR	ADDRESS	25a RECEIVED BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Warner E. Pumphrey Inc.	8434 Ga. Ave Silver Spring, Md.	FEB 19 1969	

VR AT5ME (5-67)
10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02714

CERTIFICATE OF DEATH

02703

TO HOSPITAL OR ATTENDING PHYSICIAN: the law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. DECEASED-NAME (Type or print) First / Middle / Last	JAMES CLINTON SPENCER	2a. DATE OF DEATH Month / Day / Year	2 - 23 - 69	2b. HOUR	1:25 P M
3. SEX	MALE	4. RACE	CAUCASIAN	5. DATE OF BIRTH	6-13-04
6. AGE (In years last birthday)	64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	UNITED STATES	7b. CITIZEN OF WHAT COUNTRY?	UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. COUNTY OF DEATH	MONTGOMERY Md				
10. CITY OR TOWN OF DEATH	TAKOMA PARK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	WASHINGTON SANITARIUM	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	PROFESSIONAL GOLFER
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland D.C.	13b. COUNTY		13c. CITY OR TOWN	WASH. D.C.
13d. INSIDE CITY LIMITS?	YES [X] NO [ ]	13e. STREET AND NUMBER	2726 CONN. AVE, N.W.		
14. FATHER'S NAME First / Middle / Last	JOSEPH SPENCER	15. MOTHER'S MAIDEN NAME First / Middle / Last	SARAH ARRINGTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	NO	(If yes give war or dates of service)		16b. SOCIAL SECURITY NO	578-14-8034
17. INFORMANT Address	PATIENT'S CHART				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypoxia - Anoxia

DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Insufficiency (Acute)

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis, Emphysema Bronchiectasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteriosclerotic heart disease, corpulmonale

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from 1/31, 1969, to 2/23, 1969, that (I) (we) last saw the deceased alive on 2/22, 19 ., and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b. SIGNATURE	Bruce G. Bowden MD	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS [ ]
22c. DATE SIGNED	2/23/69				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	2/26/'69	Greenmount Cemetery	Baltimore, Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	FEB 26 1969	25b. REGISTRAR'S SIGNATURE
John A. Moran, Inc.	3000 E. Baltimore St.			Charles Jungo

VR A15 (4) 45M 1-69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02715

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02708

1 DECEASED NAME (Type or Print) First	Middle	Last
LOUISE	M.	STALLWORTH

2a DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month 2 Day 15 Year 1969 — 2b HOUR 6 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Female	Cauc.	4/ 25/ 04	64 YRS				

2c DATE PRONOUNCED DEAD Month February Day 15 Year 19 69 — 2d HOUR 6 PM

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH
New York	United States		MONTGOMARY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	HOLY CROSS OF SILVER SPRING	Housewife	own home

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Montgomary	Wheaton	YES ☒ NO ☐	12707 Helen Road

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
(Unkaown)		Westbrook	(Unknown)		

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
No	--	No	Jeanne Hunter 12707 Helen Road, Wheaton, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute Coronary Insufficiency — APPROX. MATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Artery Heart Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Heap M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) BELDEN R. HEAP M.D. ADDRESS (Street, City, Town or County) Wheaton

22b. DATE SIGNED Feb. 15, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	2-20-1969	Arlington National Cemetery	Arlington, Virginia

FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
C. Glen Carter Warner E. Pumphrey, Inc.	Sil. Spr. Md. 8434 Goergia Avenue	FEB 20 1969	William A. Hodge

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

Items 18-22a Film 410
3-24-69 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02716

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02710

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	Month Day Year	2b HOUR
Mary [redacted]	ELIZABETH	STANTON	X / ☐	2-28-69 19	M

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	7-25-06	82 YRS.			2 28-69 19	5:47 PM

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / W.DOWED / DIVORCED	9. COUNTY OF DEATH
Virginia	USA	☐ / ☐ / ☐ / X	Montgomery Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Takoma Park	Wash. San. & Hosp.		

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	P.G.	Adelphi	YES ☐ NO ☐	2211 University Blvd. E.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM		Doss	HELEN		

16a. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
No			Mr. Arthur Johnson - as above - son	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Asphyxia due to aspiration of — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1 1 X

(b) gastric contents

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES X NO ☐

21a EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month Day, Year	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
	5:30 P.M. 2-28- 1969	Deceased vomited and aspirated gastric contents

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21 f LOCATION Street or R F D No	City or Town	County	State
	Home	2211 Univ.Blvd	Hyattsville	Pr.Geo.	Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R Reap M.D

EXAMINER'S NAME (Type) Belden R. Reap, MD

CHIEF MEDICAL EXAMINER ☐
ASS.STANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X
ADDRESS (Street and town or county) [illegible]

22b DATE SIGNED March 1, 1969

23a BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	March 3. 1969	Fort Lincoln Cemetery	Colmar Manor Pr Geo Md

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Takoma Funeral Home, J. Arthur Walters, 254 Carroll St NW	MAR 4 1969	J. Charles Judge

VR A15ME (5) 10M REV 1/68

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Items 18&22a Film 409 MARYLAND STATE DEPARTMENT OF HEALTH
2-26-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02717 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 0271i

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR
Joseph	N.	Starkey, Jr.	☐ ☒	2-	5-	69	7:45A

3 SEX	4. RACE	5 DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR
Male	Wh.	4/23/15	53 YRS					February	5,	1969	7:45A

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Rockville, Md. U.S.A.			Montgomery County Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Silver Spring	1215 Fidler Lane	Civil engineer	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Montgomery	Silver SPring	YES ☒ NO ☐	1215 Fidler Lane

14 FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last
Joseph N. Starkey	Edna Merie Moulden

16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
yes	214-03-3368	Hilda S. Gray	718 Chesapeake St. Silver Spring, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Fatty metamorphosis of liver and — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

571.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary tuberculosis; bilateral

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D No	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspect on ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Belden R. Leap M.D

EXAMINER'S NAME (Type) BELDEN R. LEAP M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, City, Town or County)

22b DATE SIGNED Feb. 5, 1969

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
burial	2/8/69	Rockville Cemetery	Rockville, Md.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.	FEB 7 1969	

VR A15ME (5) 10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02718 0271

1. DECEASED-NAME (Type or print): First Eileen; Middle Mary; Last Steinkraus
2a. DATE OF DEATH: Month February Day 11 Year 1969
2b. HOUR: 9:21 P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 2 August 1927
6. AGE (In years last birthday): 41 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): New York
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): The Clinical Center
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Registered Nurse
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: New York
13b. COUNTY:
13c. CITY OR TOWN: Farmingdale Long Island
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 111 Michel Avenue
14. FATHER'S NAME First Nicholas; Middle; Last Schnell
15. MOTHER'S MAIDEN NAME First Ruth; Middle; Last Bowner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO: 111-20-3951
17. INFORMANT: The Medical Record Address: The Clinical Center, NIH, Bethesda, Md. 20014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypoxia secondary to airway obstruction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Left frontal glioblastoma multiforme — 20 Months
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 14 Jan. 69
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Increased intracranial pressure
20a. AUTOPSY? YES [X] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 14 Dec., 1968, to 11 Feb., 1969, that (I) (we) last saw the deceased alive on 11 February 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Howard H. Kaufman, MD — DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. DATE SIGNED: 12 February 1969
22d. PHYSICIAN'S NAME (Type): Howard H. Kaufman, M. D.
22e. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md. 20014

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/17/1969
23c. NAME OF CEMETERY OR CREMATORY: Long Island National
23d. LOCATION (City or Town) (County) (State): Long Island N.Y.
24. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home 1331 Rockville Pike Rockville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 14 1969
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

02719

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02713

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1 DECEASED NAME (Type or print) First: ANDREW Middle: M Last: STEPHENS

2a DATE OF DEATH Month: FEB Day: 20 Year: 1969

2b HOUR: 1830 PM

3 SEX: MALE

4 RACE: WHITE

5 DATE OF BIRTH: 2/12/20

6 AGE (In years last birthday): 49 YRS

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS: HOURS / MIN

7a BIRTHPLACE (State or foreign country): MD

7b CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9 COUNTY OF DEATH: MONTGOMERY

10 CITY OR TOWN OF DEATH: BETHESDA

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SUBURBAN

12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): SALESMAN

12b KIND OF BUSINESS OR INDUSTRY: [illegible]

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: VIRGINIA

13b COUNTY:

13c CITY OR TOWN: FALLS CHURCH

13d INSIDE CITY LIMITS? YES ☐ NO ☐

13e STREET AND NUMBER: 1314 KENSINGTON PLACE

14 FATHER'S NAME First: CARL Middle: MERRIAM Last: STEPHENS

15 MOTHER'S MAIDEN NAME First: LAURA Middle: LEE Last: MAHON

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): 1942 - 45

16b SOCIAL SECURITY NO:

17 INFORMANT Address: DAVID STEPHENS - [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ABDOMINAL CARCINOMATOSIS

DUE TO, OR AS A CONSEQUENCE OF

(b): CARCINOMA OF ASCENDING COLON

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CARCINOMA OF COLON, BRONCHOPNEUMONIA & PULMONARY EDEMA

19a DATE OF OPERATION:

19b CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a AUTOPSY? YES ☐ NO ☐

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f LOCATION Street or R.F.D. No. City or Town County State

22a I certify that (I) (this hospital) attended the deceased from 12/9, 1968 to 2/20, 1969, that (I) (~~we~~) lost sow the deceased alive on 2/20 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b SIGNATURE: Michael M. Healy M.D. DEGREE: ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 2/12/69

22d. PHYSICIAN'S NAME (Type): Michel M. HEALY

22e. ADDRESS: 5411 W. Cedar La, Bethesda Md

23d BURIAL/CREMATION/REMOVAL (Specify)

23b DATE: 2-21-69

23c NAME OF CEMETERY OR CREMATORY: Cedar Hill

23a. LOCATION (City or Town) (County) (State): Suitland Maryland

24 FUNERAL DIRECTOR: [illegible]

ADDRESS: [illegible]

25a RECD BY REGISTRAR DATE: FEB 24 1969

25b REGISTRAR'S SIGNATURE:

VR A1 (VS) 45M - 1-69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 5/67
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02720 02714

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Mollie	Jane	Stewart	2	21	69	5:45 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN
Female	white	4-7-90	78 YRS				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH
Virginia	U.S.A.		Montgomery Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Wheaton	Wheaton M.H	Bureau of Engraving	Gov't.

13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montgomery	Wheaton	YES ☑ NO ☐	2803 Hathaway Terr.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Samuel	Bigler	Jamison	Mary	Jane	Brown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	---	220-44-2113	Mary E. Jamison	214 Cabell St. Lynchburg, Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute coronary artery insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery atherosclerosis — Known 18 yrs

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis — Unknown

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from Aug 21, 19 ~~67~~, to Feb 21, 1969, that (I) (~~we~~) last saw the deceased alive on Feb 17, 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED
Aaron H. Traum	MD		Feb 21 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Aaron H. Traum, M.D.	8237 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-24-1969	Ft. Lincoln Cemetery	Prince Georges, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. Glen Carter Warner E. Pumphrey, Inc.	Sil. Spr., Md. 8434 Georgia Avenue	FEB 26 1969	Richard Judge

1

02723

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02715

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First: Elizabeth	Middle: ~~None~~ UMPLEBY	Last: Stock	2a DATE OF DEATH Month: Feb Day: 5 Year: 1969	2b. HOUR: 3:55 PM	
3 SEX: Female	4 RACE: Cauc.	5 DATE OF BIRTH: 2/10/06	6 AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a BIRTHPLACE (State or foreign country): PA.	7b CITIZEN OF WHAT COUNTRY?: Amer.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: WASH. MONTGOMERY Md		
10 CITY OR TOWN OF DEATH: Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): WASH. San & Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: MD	13b. COUNTY: WASH. Mont.	13c CITY OR TOWN: Takoma Park	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: 7607 Maple Ave	
14. FATHER'S NAME First: Curtis	Middle: Q	Last: Umpleby	15. MOTHER'S MAIDEN NAME First: Viola	Middle: N	Last: Jones.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown	(If yes give war or dates of service)	16b SOCIAL SECURITY NO: 167-36-5274	17 INFORMANT: Pt's Chart	Address: 7600 Carroll Ave	

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Arrest. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15-20 Min

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Toxicity due to Obst of Liver bile duct. 6 Months

DUE TO, OR AS A CONSEQUENCE OF (c): Adenocarcinoma Pt Ovary c Metastasis 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Adenocarcinoma Metastasis to Liver and Bile ducts c Obst

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify med.cal examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 3/23/66, 19[illegible], to Feb 5, 1969, that (I) (we) last saw the deceased alive on Feb 5 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE: Howard T Morse DEGREE	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c DATE SIGNED: Feb 5, 1969	
22d PHYSICIAN'S NAME (Type): Howard T Morse, MD	22e ADDRESS: 7030 Carroll Ave Takoma Park Md		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Feb. 9. 1969	23c. NAME OF CEMETERY OR CREMATORY: Lewisburg Cemetery	23d LOCATION (City or Town): Lewisburg	(County) (State): Penna
24 FUNERAL DIRECTOR: J. Arthur Walters	ADDRESS: 254 Carroll N.W. Wash D.C.	25a. RECD BY REGISTRAR DATE: FEB 7 1969	25b REGISTRAR'S SIGNATURE: [illegible]	

VR A15 (4)
30M REV. 1/68

1

02722

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02716

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b. HOUR
Edward	C.	Stull	2 14 69	1 22 AM

3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	2-4-01	68 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
D.C.	U.S.A.	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Montgomery Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital	Retired	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md	Montgomery	Silver Spring	YES ☐ NO ☐	1400 Fenwick Lane

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Edward	J.	Stull	Lillie		Heffner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	Address
No		579-18-7321	Mrs. Lonnie M. Stull	1400 Fenwick Lane Silver Spring Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	bronchopneumonia	
DUE TO, OR AS A CONSEQUENCE OF (b)	cerebral arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF (c)		

150 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

prostatectomy - pleurisy - chronic bronchitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2/15, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 2/15 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
Lewis Dillard Dennis	MD	☐	☐	☐	2/14/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Lewis Dillard Dennis	9516 Rockville Pike Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	2/17/1969	Potomac Meth. Ch. Cem.	Potomac	Montg.	Md.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home, 1331 Rockville Pike, Rockville, Md	FEB 19 1969	

VR A15
30M REV 1-68

1

02723
Item5 Film 410 3/7/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

0271

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1'69

1 DECEASED NAME (Type or print)	First: MAbel	Middle: G.	Last: Suit	2a. DATE OF DEATH Month: 2	Day: 19	Year: 69	2b HOUR: 5:25 PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: January 14-94	6 AGE (In years last birthday): 75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a BIRTHPLACE (State or foreign country): Georgetown D.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery	Md			
10 CITY OR TOWN OF DEATH: Bethesda.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md. Maryland	13b COUNTY: Prince Georges	13c CITY OR TOWN: Mt. Rainer	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 3705 36th Street.			
14 FATHER'S NAME First: John.	Middle: Granger.	Last:	15. MOTHER'S MAIDEN NAME First: Annie	Middle:	Last: Ryan.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT: John M. Suit	Address: Same.			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4123
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town / County / State

22a I **certify** that (I) (this hospital) attended the deceased from Jan, 19 68, to 2-19, 19 69, that (I) (we) last saw the deceased alive on 2/19/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Paul D. Carter M.D. DEGREE — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 2/20/69

22d. PHYSICIAN'S NAME (Type) — 22e ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 2/24/69	23c NAME OF CEMETERY OR CREMATORY: Bethel	23d LOCATION (City or Town) (County) (State): Alexandria, Virginia	
24 FUNERAL DIRECTOR: Walter T. Hall	ADDRESS: Cunningham Funeral Home, Inc. Alex., Va.	25a RECD BY REGISTRAR DATE: FEB 24 1969	25b REGISTRAR'S SIGNATURE: [illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02724

CERTIFICATE OF DEATH

02718

1 DECEASED-NAME (Type or print) First: Robert Middle: M. Last: Talbot

2a. DATE OF DEATH Month 2 Day 21 Year 69

2b. HOUR 8:55 a M

3 SEX: Male

4. RACE: White

5. DATE OF BIRTH: 1/13/87

6 AGE (In years last birthday): 82 YRS. IF UNDER 1 YEAR MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN

7a BIRTHPLACE (State or foreign country): Ny ~~[illegible]~~

7b CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Montgomery Md.

10 CITY OR TOWN OF DEATH: Wheaton

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Randolph Hills Nursing Home.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)

12b KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Va.

13b COUNTY: Arlington

13c CITY OR TOWN: Arlington

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e STREET AND NUMBER: 1111 Quincy St.

14 FATHER'S NAME First: David Middle: Last: Talbot

15. MOTHER'S MAIDEN NAME First: Jane (~~unknown~~) Middle: Craig Last: Hately ~~[illegible]~~

16a. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): Yes (If yes give war or dates of service): WWI

16b SOCIAL SECURITY NO: 064-16867-A

17 INFORMANT: Robert Bennett, 29 Ralph Avenue Address: Ronkona Lake, L.I. New York

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hodgkins Disease

201X

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐

21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING, ETC)

21f LOCATION Street or R.F.D No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 2/15, 1969, to 2/21, 1969, that (I) (we) last saw the deceased alive on 2/19 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: [signature]

DEGREE: ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22c DATE SIGNED: 2/21/69

22d. PHYSICIAN'S NAME (Type): Allan Cohen

22e ADDRESS: 13515 Ga. Avenue Silver Spring, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE: Feb. 24, 1969

23c NAME OF CEMETERY OR CREMATORY: Monticello Cemetery

23d. LOCATION (City or Town) (County) (State): ~~Charlottesville~~, Charlottesville Va.

24 FUNERAL DIRECTOR: Glen Carter C. Glen Carter — ADDRESS: Md. Warner E. Pumphrey, Inc. 8434 Ga. Ave. Sil. Spg.

25a. REC'D BY REGISTRAR DATE: FEB 26 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 30M REV 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02725 — 02719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First: Gwendolen Middle: D. Last: Tate	2a DATE OF DEATH Month: 2 Day: 3 Year: 69	2b HOUR: 9:30 PM	
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: 11-23-99	6 AGE (In years last birthday): 69 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): England	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Montgomery. Md.
10 CITY OR TOWN OF DEATH: Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Suburban	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE	12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Montgomery	13c CITY OR TOWN: Bethesda	13d INSIDE CITY LIMITS? YES [X] NO [ ] 13e. STREET AND NUMBER: 10607 Weymouth St.
14 FATHER'S NAME First: Samuel Middle: G. Last: Smith	15 MOTHER'S MAIDEN NAME First: Fannie Middle: Derrick Last:		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 561-09-9356	17 INFORMANT: Robert Tate Address: (Same)	

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Acute Myelogenous Leukemia	3 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from November, 1968, to 2/2, 1969, that (I) ~~(we)~~ last saw the deceased alive on 2/2 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b SIGNATURE: J. Blaine Fitzgerald DEGREE	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ]	22c DATE SIGNED: 2/3/69.	
22d PHYSICIAN'S NAME (Type): J. BLAINE FITZGERALD	22e ADDRESS: 8218 Wisconsin Ave, Bethesda, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE: FEB. 7 1969	23c NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY	23d LOCATION (City or Town) (County) (State): ROCKVILLE, MONTGY MD.
24 FUNERAL DIRECTOR: Jos. Gawler Sons Inc.	ADDRESS: 5130 Wisconsin Ave N.W. Washington D.C.	25a RECEIVED BY REGISTRAR DATE: FEB 10 1969	25b REGISTRAR'S SIGNATURE:

VR A15 (Rev. 45M - 1-69)

T 61

Items 18-22a film 410
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02726

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02720

1. DECEASED-NAME (Type or Print)	First: Alfredo	Middle	Last: Teodosio	2a. DATE KNOWN OF DEATH / ESTIMATED	Month: 2-	Day: 24-	Year: 1696	2b. HOUR: 55 M	
3. SEX: M	4. RACE: Canc.	5. DATE OF BIRTH: JAN. 29. 1903	6. AGE (In years last birthday): 66 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 2-24- / Day / Year 69	2d. HOUR: 6:55 M		
7a. BIRTHPLACE (State or foreign country): Portugal	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md						
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): HOLY CROSS HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): CONSTRUCTION WORKER	12b. KIND OF BUSINESS OR INDUSTRY: SAME						
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Takoma Park	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: #9 Philadelphia Ave.					
14. FATHER'S NAME: First / Middle / Last: Teodosio	15. MOTHER'S MAIDEN NAME: First: Not / Middle: available / Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 118-14-6257	17. INFORMANT: Mrs. Mona Kenyon	ADDRESS: 230 Park Ave Takoma						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Multiple extreme injuries including

DUE TO, OR AS A CONSEQUENCE OF

(b): avulsive transection of aortic arch

DUE TO, OR AS A CONSEQUENCE OF

(c): with exsanguination

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROX. INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	6:42 PM 2-24 19 69	Deceased, driver, lost control of car and was struck by car and rolled down ramp embankment

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State
	Street	Silver Spring Montg. Md.

22a. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Belden R. Reap M.D.

EXAMINER'S NAME (Type): BELDEN R. REAP M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Potomac

22b. DATE SIGNED: Feb. 24, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	2-27-1969	Congressional	Laud- Md

24. FUNERAL DIRECTOR (ADDRESS): Arthur Walters 254 Carroll St NW

25a. REC'D BY REGISTRAR DATE: FEB 28 1969

25b. REGISTRAR'S SIGNATURE: Thomas Yeager

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02723

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0272

1 DECEASED NAME (Type or Print)	First: William.	Middle: Joseph	Last: Thomas.	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ]	Month: Feb	Day: 8	Year: 1969.	2b HOUR: 8.51 A M
3 SEX: M.	4 RACE: Negro.	5 DATE OF BIRTH: Aug 27 1925	6 AGE (In years last birthday): 43 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month Feb.	Day 8	Year 1969	2d HOUR: 9.25 A M

7a BIRTHPLACE (State or foreign country): Md.	7b CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md	
10. CITY OR TOWN OF DEATH: Rockville.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): B+O Rail Road Track.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Tile Layer	12b. KIND OF BUSINESS OR INDUSTRY	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b COUNTY: Montgomery	13c CITY OR TOWN: Rockville	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: 203 Frederick Ave.

14 FATHER'S NAME First: Peter	Middle / Last: Thomas	15 MOTHER'S MAIDEN NAME First: Jannie	Middle / Last: Magruder

16a WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): YES	(If yes give war or dates of service): WW II	16b SOCIAL SECURITY NO	17 INFORMANT: Mabel Thomas (Wife) ADDRESS: Rockville md

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Multiple Injuries Severe — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

805 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Trauma from being Struck by Train.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.: 8.21 Feb 8 1969	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18): Walking on track. Struck by Train.	
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.): R.R. Track B+O.	21f LOCATION Street or R F D No / City or Town / County / State: Near 822 Rockville Pike Rockville Montgomery Md	

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: John G. Ball M.D

EXAMINER'S NAME (Type): John G. BALL

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS (Street, city, town, or county)

22b DATE SIGNED: Feb. 8, 1969

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE: 2-11-69	23c NAME OF CEMETERY OR CREMATORY: Gate of Heaven	23d LOCATION (City or Town) (County) (State): Silver Spring Monty Md	
24 FUNERAL DIRECTOR: Robert L. Snowden	ADDRESS: Rockville, Md.	25a REC'D BY REGISTRAR DATE: FEB 13 1969	25b REGISTRAR'S SIGNATURE	

VR A15ME (5)
10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02728 02722

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First: Robert	Middle: Mitchell	Last: TIMS	2a. DATE OF DEATH Month: February Day: 24 Year: 69 — 2b HOUR: 852A M
3. SEX: Male	4. RACE: White ~~Caucasian~~	5 DATE OF BIRTH: March 18, 1923	6. AGE (In years last birthday): 45 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): Tennessee	7b CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.
10 CITY OR TOWN OF DEATH: Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Naval Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): U. S. Navy	12b KIND OF BUSINESS OR INDUSTRY: Armed Forces
13a USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: Florida	13b COUNTY: Brevard	13c CITY OR TOWN: Titusville	13d INSIDE CITY LIMITS? YES [X] NO [ ] — 13e STREET AND NUMBER: 4322 Alachua Avenue
14 FATHER'S NAME First: Sim	Middle:	Last: TIMS	15 MOTHER'S MAIDEN NAME First: Unknown Middle: Last:
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes	If yes give war or dates of service: 1940-64	16b SOCIAL SECURITY NO: 534 38 6927	17 INFORMANT: Mrs. Gertrude Tims, 4322 Alachua Avenue Titusville Address Florida

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

1621

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of the lung (ACTH secretion with secondary

DUE TO, OR AS A CONSEQUENCE OF (c): Cushing's Syndrome

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [X] NO [ ]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from Feb. 14, 1969, to Feb. 24, 1969, that (I) (we) last saw the deceased alive on Feb. 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: C. S. Crummy M.D. DEGREE	ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [X]	22c DATE SIGNED: Feb. 25, 1969	
22d. PHYSICIAN'S NAME (Type): C. S. CRUMMY, M. D.	22e. ADDRESS: Naval Hospital, Bethesda, Md.		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 2/27/69	23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.	23d LOCATION (City or Town): Arlington,	(County): Arlington (State): Va.
24. FUNERAL DIRECTOR ADDRESS: Ritchie Bros. Funeral Home, Upper Marlboro, Maryland	25a RECD BY REGISTRAR DATE: MAR 3 1969	25b. REGISTRAR'S SIGNATURE: Florence Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02729 02723

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First: Sara Middle: Ann Last: Tretler

2a DATE OF DEATH Month: 2 Day: 7 Year: 69 | 2b HOUR 10:45 PM

3 SEX: F | 4 RACE: W | 5 DATE OF BIRTH: 6-17-88 | 6 AGE (In years last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS: HOURS MIN

7a BIRTHPLACE (State or foreign country): Md. | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9 COUNTY OF DEATH: Montgomery Md

10 CITY OR TOWN OF DEATH: Takoma Park | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington San & Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE | 12b KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md. | 13b. COUNTY: Pri. Geo | 13c. CITY OR TOWN: Greenbelt | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e STREET AND NUMBER: 6005 Cherrywood

14 FATHER'S NAME First: CHARLES Middle: Last: GUYTHER | 15. MOTHER'S MAIDEN NAME First: IDA Middle: Last: LAMBETH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service) | 16b SOCIAL SECURITY NO: 579-22-2360A | 17 INFORMANT: Charles U. Tretler Address: 5811 Skyline Drive Wash. D.C. 2002 3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Pulmonary Embolus. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Arteriosclerotic Cardiovascular Disease.

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC) | 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 3, 1965, to 2-7, 1965, that (I) ~~(we)~~ last saw the deceased alive on 2-7 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b SIGNATURE: Morton Altschuler | DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ | 22c DATE SIGNED: 2-7-69

22d. PHYSICIAN'S NAME (Type): Morton Altschuler. | 22e ADDRESS: 9205 New Hampshire Ave Silver Spring Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIEL | 23b. DATE: 2-11-69 | 23c NAME OF CEMETERY OR CREMATORY: Gate of Heaven | 23d LOCATION (City or Town) (County) (State): Silver Spring, Maryland.

24 FUNERAL DIRECTOR: [illegible] ADDRESS: [illegible] | 25a REC'D BY REGISTRAR DATE: FEB 11 1969 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M

MARYLAND STATE DEPARTMENT OF HEALTH

02730 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02724

Information taken from birth cert **CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
VEIHMEYER,	Daniel	Christopher	2	15	69	3:52 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	2-17-69				7	40

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	HOLY CROSS		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Prince George's	Laurel		15904 Kerr Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
FREDERICK	D	VEIHMEYER	MAVREEN	K	VEIHMEYER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
		FREDERICK DVEIHMEYER 15904 KERR RD LAUREL, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) IMMATURITY — 9 hrs

77.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Idiopathic Respiratory Distress Syndrome. — 9 hrs.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Meta Bolic Acidosis, Sepsis, Congestive Heart Failure.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☑ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			NO

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 2/14/69, 19 69, to 2/15/69, 19____, that (I) (we) last saw the deceased alive on 2/14/69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS	22c. DATE SIGNED
Gary Brecher	MD	☑	☐	☐	2/17/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Gary Brecher	50 W. Edmonston Ave., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/19/69	Gate of Heaven Cemetery	Silver Spring, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home 1331 Rock. Pike Rockville, Maryland	FEB 21 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M) 30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02695 02725

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
VINES		ROLAND	February 9 69	1:05 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
F	NEGRO	7-27-1888	80 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
N. CAROLINA	U.S.A.		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
WHEATON	UNIVERSITY NURSING HOME		

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
D.C.	WASHINGTON	→	YES ☒ NO ☐	1310 BUCHANAN St., N.W. D.C. 20001

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
UNKNOWN	UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
		MRS. ESTHER COBB	as pt's

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis — years

DUE TO, OR AS A CONSEQUENCE OF (c)

4107 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 2/4, 19 69, to 2/9, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 2/8, 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
David Allsworth, M					2/9/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Removal	2/11/1969	Ship To	Rocky Mount, N.C.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W.E. Ernest Jarvis Co., Inc. W.E. Jarvis Funeral Home	1432 U Street, N.W. 1432 U St. N.W.	FEB 13 1969	

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02731 02726

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Thomas	Middle: McGaw	Last: Walker	2a. DATE OF DEATH: Month 2 Day 2 Year 1969
2b. HOUR: 7 P M			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 4-15-07	6. AGE (In years last birthday): 61 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: Amer.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md
10. CITY OR TOWN OF DEATH: Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Washington Sanitarium & Hosp. Sme	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Salesman	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Md.	13b. COUNTY: Prince George	13c. CITY OR TOWN: Chillum	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: 815 Chillum Rd.
14. FATHER'S NAME First: Bernard	Middle	Last: Walker	15. MOTHER'S MAIDEN NAME First: Blanche	Middle	Last: Fossett
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: unknown	17. INFORMANT: Hospital Record Address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: several months
41
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary Congestion — 8 hours
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
(1) Ulcerative Colitis (2) Rt Lobar Pneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED White [ ] Not white [ ] at work [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from Jan 4, 1969, to Feb 2, 1969, that (I) (we) last saw the deceased alive on Feb 2 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: James M Whitlock M D — DEGREE — ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED: Feb 3 1969

22d. PHYSICIAN'S NAME (Type): James M Whitlock — 22e. ADDRESS: 7717 Carroll Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Feb 6, 1969	23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery	23d. LOCATION (City or Town): Washington D C	(County) (State)
24. FUNERAL DIRECTOR: F. Gasch's Sons	ADDRESS: Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE: FEB 7 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

VR A15 (4) 45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

V III A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02732 0272?

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
CAMILLA	LEARY	WALTERS	FEB 19 1969	6:30 PM

3. SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	CAUC.	5 27 95	73 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH
VA.	U.S.A.		MONTGOMERY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
KENSINGTON	KENSINGTON GARDENS	HOUSEWIFE	AT HOME

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	PR GEO	RIVERDALE	YES ☑ NO ☐	5714 EAST PINE DR.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ROSS	I.	LEARY	ELIZABETH		DARNEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	Address
	228-34-9948	WILLIAM B. WALTERS, SON,	5714 EAST PINE DR. RIVERDALE, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) ADENOCARCINOMA OF STOMACH — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 MOS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

PARKINSON'S DISEASE

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12-8-68	GASTRIC RESECTION FOR CA.	YES ☐ NO ☑	

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-4, 1965, to 2-19, 1969, that (I) (we) last saw the deceased alive on 2-15 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c DATE SIGNED
C. J. Houmann		☑	☐	☐	19 FEB '69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
C. J. HOUMANN M.D.	RIVERDALE MD. 20840

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	2-20-1969		Whaleyville, Virginia

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REG STRAR DATE	25b REGISTRAR'S SIGNATURE
Joseph Gawler's Sons, Inc., 917 Wisc. Ave. N.W., Wash., D.C., 20016	FEB 24 1969	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02733

CERTIFICATE OF DEATH

02723

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
PERCY	WELLINGTON	WARD	2	8	69	7:45 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
MALE	WHITE	10/16/02	66 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
MARYLAND	UNITED STATES		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
OLNEY	MONTGOMERY GENERAL		SANITATIO N

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	MONTGOMERY	GAITHERSBURG	YES [X] NO [ ]	23 CEDAR AVENUE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
IGNATIUS		WARD	ALBERTA		DAVIS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
No	216-38-3414	Hospitol Records	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pancreatic Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarct — days

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—		—

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Jan 31, 1969, to Feb 8, 1969, that (I) (we) last saw the deceased alive on Feb 7, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
Steven Conway MD	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS. [ ]	2-8-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
STEVEN CONWAY MD	570 NO FREDERICK Gaithersburg Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-10-69	Forest Oak	Gaithersburg, Maryland Montg

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ernest C. Gartner	Gaithersburg, Md.	FEB 13 1969	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02734 02729

1. DECEASED-NAME (Type or print) First: ~~[illegible]~~ Guy	Middle: Harris	Last: White	2a. DATE OF DEATH Month 2 Day 17 Year 69 — 2b. HOUR 9:55 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: April 9, 1879	6. AGE (In years last birthday) 89 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (State or foreign country) Wash., D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 1912 Glen Ross Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Dentist	12b. KIND OF BUSINESS OR INDUSTRY: Self-employed
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Sil. Spr.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 1912 Glen Ross Road
14. FATHER'S NAME First: George	Middle: --	Last: White	15. MOTHER'S MAIDEN NAME First: Marian — Middle: -- — Last: Harris
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes give war or dates of service) --	16b. SOCIAL SECURITY NO: 216-46-9245	17. INFORMANT: Marion Palmer White — Address: Silver Spring, Md. 1912 Glen Ross Road

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) general inanition — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr
4404
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) advanced arteriosclerosis — 5 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 7-15, 1965, to 2-17, 1969, that (I) ~~(saw)~~ last saw the deceased alive on 2-17 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(saw)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE			22c. DATE SIGNED
D. F. Sengstack MD	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	2-17-69
22d. PHYSICIAN'S NAME (Type) G. F. Sengstack	22e. ADDRESS 9241 Columbia Blvd. Silver Spring, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-20-1969	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) Washington, D. C. (County) (State)
24. FUNERAL DIRECTOR P. J. Smith Funeral Home	ADDRESS Sil. Spr., Md. Warner E. Pumphrey, Inc. 8434 Georgia Avenue	25a. RECD BY REGISTRAR DATE FEB 21 1969	25b. REGISTRAR'S SIGNATURE Florence Yingst

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02735 02730

1. PLACE OF DEATH
a. COUNTY: Montgomery County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Echo Heights
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6401 Walhonding Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Echo Heights
d. STREET ADDRESS: 6401 Walhonding Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle C Last Wiggington

4. DATE OF DEATH: Month February Day 3 Year 1969

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 22, 1904

9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house painter

10b. KIND OF BUSINESS OR INDUSTRY: construction

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Augusta Wiggington

14. MOTHER'S MAIDEN NAME: Ida F. Armstrong

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): –
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 220-28-5686

17. INFORMANT: George J. Wiggington, Son, 523 Pinewood Road, Address Rockville, Maryland, 20850

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Myocarditis, Chronic — 5 months

DUE TO (c): Coronary Heart Disease — 5 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (~~witness~~) attended the deceased from October 11 1968 to February 3, 1969, that (I) (~~xx~~) last saw the deceased alive on February 3 1969, and that death occurred at 11:25 P.M. from the causes and on the date stated above

22a. SIGNATURE: M. van Kinsbergen M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: February 3, 1969

22c. PHYSICIAN'S NAME (Type): Maurice van Kinsbergen

22d ADDRESS: 5715 Mass. Ave. Washington DC 20016

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-7-1969

23c. NAME OF CEMETERY OR CREMATORY: Raymouth Church Cemetery

23d LOCATION (City, town, or county) (State): Stafford County, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016

25a. REC'D BY REGISTRAR DATE: FEB 7 1969

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02736 02731

1. DECEASED-NAME (Type or print): First DANIEL Middle E. Last WILLARD
2a. DATE OF DEATH: February (Month) 2 (Day) 1969 (Year)
2b. HOUR: M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: June 19, 1907
6. AGE (In years last birthday): 61 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Md.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 5010 Alta Vista Rd.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): President Poultry Firm
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Montgomery
13c. CITY OR TOWN: Bethesda
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 5010 Alta Vista Rd.
14. FATHER'S NAME First Middle Last: Daniel S. Willard
15. MOTHER'S MAIDEN NAME First Middle Last: Mary Bassford
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16b. SOCIAL SECURITY NO.: 578 03 5802
17. INFORMANT Address: Madge L. Willard (Same as above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of prostate with Metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED Whire at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2-2, 1969, that (I) (we) last saw the deceased alive on 2-2 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Isidore Shulman M.D. DEGREE — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 2-3-69
22d. PHYSICIAN'S NAME (Type): Isadore Shulman M.D.
22e. ADDRESS: 915-19th St NW Wash D.C.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE: 2/6/69
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.
23d. LOCATION (City or Town) (County) (State): Frederick Fred. Co. Md.
24. FUNERAL DIRECTOR ADDRESS: Tyson Wheeler F.H. 1331 Rockville, ~~Rockville~~ Pike Rockville, Maryland
25a. REC'D BY REGISTRAR DATE: FEB 6 1969
25b. REGISTRAR'S SIGNATURE: Roland Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4) 30M REV. 1/68

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02737 — 02732

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN ☑ OF DEATH ESTIMATED ☐ Month	Day	Year	2b. HOUR 5:32 P M
GRACE	E	WILLIAMS	FEB	24	1969	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d HOUR
FEMALE	WHITE	July 15, 1888	80 YRS					FEB	24	1969	10:35 P M

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH			
Missouri	U S A		MONTGOMERY			Md
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY			
BETHESDA	SUBURBAN	REGISTERED NURSE				
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER		
MARYLAND	MONTGOMERY	BETHESDA	YES ☐ NO ☐	8710 GARFIELD ST		

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last			
MELVILLE	EVERETT		MIRIAM		O'REAR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT	ADDRESS				
NO		579-22-1786	MARY W. TAYLOR - DAUGHTER -	SAME				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Coronary Insufficency. Acute - — Approximate Interval Between Onset and Death: Sudden.

DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease — Years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. 1124

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE John G. Ball M D

EXAMINER'S NAME (Type) John G Ball

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) 7936 Old Geo. Rd Bethesda, Md

22b. DATE SIGNED Feb 24 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)	
Cremation	2-25-69	Cedar Hill Crematory	Suitland Pr. Geo. Md	
24 FUNERAL DIRECTOR	7557 Wisconsin Ave	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE	
Robert A Pumphrey	Bethesda, Md	FEB 26 1969	[signature]	

VR AT5ME
TOM REV 1-68

Item 18 Film 410 3-10-69a

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02738

CERTIFICATE OF DEATH

02733

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CHARLES	JUNIOR	WOOD	FEBRUARY 21 1969	8:13 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
MALE	CAUC	SEPT 20, 1912	56 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
GEORGIA	UNITED STATES		MONTGOMERY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NAVAL HOSPITAL	NAVY	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	MONTGOMERY	BETHESDA	YES ☒ NO ☐	10630 KENILWORTH AVE.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CHARLES	DAVIES	WOOD	SARAH	LILLIAN	CAGLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	WW2	561-54-5731	MRS. CATHERINE WOOD	10630 KENILWORTH AVE, BETH., MD.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) DEFERRED/PENDING FINAL AUTOPSY RESULTS — Acute myocardial infarct

DUE TO, OR AS A CONSEQUENCE OF (b) secondary to occlusive coronary atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Adrenals: Autolysis, bilateral, severe; Pancreas: Autolysis, severe

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	YES

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 21 FEBRUARY 1969, to 21 FEBRUARY 69, that (I) (we) last saw the deceased alive on 21 FEBRUARY 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
James N. Trone		☐	☐	☒	22 FEBRUARY 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JAMES N. TRONE, M.D.	NAVAL HOSPITAL, BETHESDA, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
REMOVAL	26 FEBRUARY 1969	ARLINGTON NATL. CEM.	ARLINGTON		VIRGINIA

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
W. W Chamberlain	1400 Chapin St	FEB 26 1969	Juliana Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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02739

Item2a Film G410 3/27/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Ronald	Middle: Joseph	Last: WOODAMAN	2a. DATE OF DEATH: Month February Day 13 Year 69
2b. HOUR: 450 M	3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: Sept. 1, 1907
6. AGE (In years last birthday): 61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Massachusetts USA	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Montgomery Md.
10. CITY OR TOWN OF DEATH: Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): U. S. Navy	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Virginia	13b. COUNTY: Fairfax	13c. CITY OR TOWN: Fairfax	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: 12816 Westbrook Drive			
14. FATHER'S NAME First Middle Last: Clinton B. R. Woodaman	15. MOTHER'S MAIDEN NAME First Middle Last: Ann Evelyn MacDonald		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: yes (If yes give war or dates of service): 1926-59	16b. SOCIAL SECURITY NO.: 224 52 8318	17. INFORMANT: Dr. Fairfax, Va. Address: Mrs. Elsa S. Woodaman, 12816 Westbrook	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ASPIRATION PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

HYDROCEPHALUS ASSOCIATED WITH CYST, FORTH VENTRICLE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that ~~I~~ (this hospital) attended the deceased from Feb. 12, 1969, to Feb. 13, 1969, that (I) (we) last saw the deceased alive on Feb. 13 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: E M Jewusiak DEGREE ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED: Feb. 14, 1969		
22d. PHYSICIAN'S NAME (Type): E.M. JEWUSIAK	22e. ADDRESS: Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/17/69	23c. NAME OF CEMETERY OR CREMATORY: Imanuel Church Cemetery	23d. LOCATION (City or Town) (County) (State): Glenco Md.
24. FUNERAL DIRECTOR: Beverly [illegible]	ADDRESS: Funeral Home, Main Street, Fairfax, Va.	25a. REC'D BY REGISTRAR DATE: FEB 17 1969	25b. REGISTRAR'S SIGNATURE

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